

CONTINUATION / CANCELLATION OF FEDERAL EMPLOYEES HEALTH BENEFIT PLAN

SUBMIT THIS FORM TO THE CO-OP OFFICE WITH AN ORIGINAL SIGNATURE AND RETAIN A COPY FOR YOUR RECORDS.

CONTINUATION OF HEALTH INSURANCE

PAYMENT OF INSURANCE

☐ I want to continue my health benefits at the cost of: _____.

PAYMENT WILL BE MADE AS INDICATED BELOW

- ☐ Every two (2) weeks
- ☐ Monthly
- ☐ In one lump sum, in advance, for the estimated period of absence
- ☐ Prefer MSFC to recover amount due from salary upon returning to work

Payment should be made by check, payable to National Aeronautics and Space Administration and mailed to:

NASA/MSFC
Office of Chief Financial Officer
Attn: RS01
Marshall Space Flight Center, AL 35812

(RS01 is located in Building 4200, Room 615;
Phone: 544-1491)

I understand that I must pay the premiums for my health benefits coverage which continues during non pay status (or during pay periods when my salary is insufficient to cover premiums, and if I do not settle before returning to work, the amount due will be recovered from my salary or any other monies owed me by the Federal Government)

SIGNATURE:

DATE:

CANCELLATION OF HEALTH INSURANCE

☐ I want more information about canceling my health benefits. (Please read the Cancellation Addendum or call 544-7536.)

☐ I will cancel my health benefits effective as soon as possible. (Please completed Health Benefits Registration Form, SF-2809. This form must be obtained from the Human Resources Office, Building 4200, Room 328 and return promptly to the same office.)

To cancel my health benefits coverage, I understand that Health Benefits Registration Form, SF-2809, must be submitted to the Human Resources Office, Building 4200, Room 328, in accordance with instructions provided to me and that if I do not take the appropriate steps to cancel the insurance, any amount due will be recovered from my salary or any monies owed me by the Federal Government.

SIGNATURE:

DATE:

EFFECTIVE DATE OF CANCELLATION OF HEALTH INSURANCE BENEFITS

If you plan to cancel your health benefits coverage, submitting your Health Benefits Registration Form, SF-2809, in accordance with the instructions, provided below, will help you avoid indebtedness for coverage you may not want.

1. Cancellation of health benefits coverage should be done the pay period before the last pay period in a work status. Coverage is not canceled unless the Health Benefits Registration Form, SF-2809 is obtained, completed, and returned to the Human Resources Office, Building 4200, Room 328. Call this office (544-7536) if you have questions concerning cancellation of coverage.
2. If you do not cancel coverage, it will be continued into the leave-without-pay status and you will be obligated to pay for premiums.
3. Cancellation takes effect at the end of the pay period in which the cancellation is received in the Human Resources Office. For example, if your last day on-board is the last Friday of the month, your SF-2809 must be submitted by the second Friday in the month.
4. Filing of cancellation should be done in sufficient time to avoid an obligation to pay for coverage which extends into any part of the leave-without-pay period.
5. Once benefits are canceled, open season is the only time you may re-enroll unless circumstances listed in Health Benefits Program Form, SF-2809, permit re-enrollment.